

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034401

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 3000 Registrar's No. 1339

FILED SEP 4 1962

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>GREENE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> | | Length of stay in 1b <u>25 DAYS</u> | c. CITY OR TOWN <u>MARSHFIELD</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOHNS HOSP</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>449 S. BUFFALO</u> |
| 3. NAME OF DECEASED (Type or print) <u>WILLARD FREEMAN JONES</u> | | 4. DATE OF DEATH Month <u>SEPT</u> Day <u>3</u> Year <u>1962</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-4-1884</u> |
| 9. AGE (last birthday) <u>78</u> | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET MERCHANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI</u> |
| 11. BIRTHPLACE (City and state or country) <u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | |
| 13a. FATHER'S NAME <u>ISSAC JONES</u> | | 13b. MOTHER'S MAIDEN NAME <u>AMANDA WILSON</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>VERBA</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | |
| 16. INFORMANT <u>VERBA JONES MARSHFIELD</u> | | 17. ADDRESS <u>VERBA JONES MARSHFIELD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prolonged debility</u> DUE TO (c) <u>Stenosis of Esophagus, benign 3wks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac insufficiency</u> <u>Pernicious anemia aortic stenosis</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>7:35</u> a.m. <u>PM</u> Month, Day, Year <u>August 9, 1962</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE |
| 21. I attended the deceased from <u>August 9, 1962</u> to <u>Sept 3, '62</u> and last saw him/her alive on <u>Sept 2, 1962</u> Death occurred at <u>735 A</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>W. Yates Trotter M.D.</u> | | 22b. ADDRESS <u>Professional Bldg Springfield MO</u> | |
| 22c. DATE SIGNED <u>9-13-62</u> | | 23. NAME OF CEMETERY OR CREMATORY <u>MANSFIELD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u> | | 23b. DATE <u>9-3-1962</u> | |
| 23c. LOCATION (City, town, or county) <u>MANSFIELD MO</u> | | 23d. DATE RECD. BY LOCAL REG. <u>9-17-62</u> | |
| 24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u> | | 25. REGISTRAR'S SIGNATURE <u>Effie S. Meelon</u> | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

perman 9-23-62